§ 414.21 Medicare payment basis.

Medicare payment is based on the lesser of the actual charge or the applicable fee schedule amount.

[62 FR 59101, Oct. 31, 1997]

§ 414.22 Relative value units (RVUs).

CMS establishes RVUs for physicians' work, practice expense, and malpractice insurance.

(a) *Physician work RVUs*—(1) *General rule.* Physician work RVUs are established using a relative value scale in which the value of physician work for a particular service is rated relative to the value of work for other physician services.

(2) *Special RVUs for anesthesia and radiology services)*—(i) *Anesthesia services.* The rules for determining RVUs for anesthesia services are set forth in § 414.46.

(ii) *Radiology services.* CMS bases the RVUs for all radiology services on the relative value scale developed under section 1834(b)(1)(A) of the Act, with appropriate modifications to ensure that the RVUs established for radiology services that are similar or related to other physician services are consistent with the RVUs established for those similar or related services.

(b) *Practice expense RVUs.* (1) Practice expense RVUs are computed for each service or class of service by applying average historical practice cost percentages to the estimated average allowed charge during the 1991 base period.

(2) The average practice expense percentage for a service or class of services is computed as follows:

(i) Multiply the average practice expense percentage for each specialty by the proportion of a particular service or class of service performed by that specialty.

(ii) Add the products for all specialties.

(3) For services furnished beginning calendar year (CY) 1994, for which 1994 practice expense RVUs exceed 1994 work RVUs and that are performed in office settings less than 75 percent of the time, the 1994, 1995, and 1996 practice expense RVUs are reduced by 25 percent of the amount by which they exceed the number of 1994 work RVUs. Practice expense RVUs are not reduced to less than 128 percent of 1994 work RVUs.

(4) For services furnished beginning January 1, 1998, practice expense RVUs for certain services are reduced to 110 percent of the work RVUs for those services. The following two categories of services are excluded from this limitation:

(i) The service is provided more than 75 percent of the time in an office setting; or

(ii) The service is one described in section 1848(c)(2)(G)(v) of the Act, codified at 42 U.S.C. 1395w–4(c)(2)(G). Section 1848(c)(2)(G)(v) of the Act refers to the 1998 proposed resource-based practice expense RVUs (as specified in the June 18, 1997 physician fee schedule proposed rule (62 FR 33158)) for the specific site, either in-office or out-of-office, increased from its 1997 practice expense RVUs.)

(5) For services furnished in 2002 and subsequent years, the practice expense RVUs are based entirely on relative practice expense resources.

(i) Usually there are two levels of practice expense RVUs that correspond to each code.

(A) *Facility practice expense RVUs.* The facility practice expense RVUs apply to services furnished to patients in a hospital, a skilled nursing facility, a community mental health center, a hospice, or an ambulatory surgical center, or in a wholly owned or wholly operated entity providing preadmission services under § 412.2(c)(5) of this chapter, or via telehealth under § 410.78 of this chapter.

(B) *Nonfacility practice expense RVUs.* The nonfacility practice expense RVUs apply to services furnished to patients in all locations other than those listed in paragraph (b)(5)(i)(A) of this section, but not limited to, a physician's office, the patient's home, a nursing facility, or a comprehensive outpatient rehabilitation facility (CORF).

(C) *Outpatient therapy and CORF services.* Outpatient therapy services (including physical therapy, occupational therapy, and speech-language pathology services) and CORF services billed under the physician fee schedule are paid using the nonfacility practice expense RVUs.

(ii) [Reserved]

(6)(i) CMS establishes criteria for supplemental surveys regarding specialty practice expenses submitted to CMS that may be used in determining practice expense RVUs.

(ii) Any CMS-designated specialty group may submit a supplemental survey.

(iii) CMS will consider for use in determining practice expense RVUs for the physician fee schedule survey data and related materials submitted to CMS by March 1, 2004 to determine CY 2005 practice expense RVUs and by March 1, 2005 to determine CY 2006 practice expense RVUs.

(c) *Malpractice insurance RVUs.* (1) Malpractice insurance RVUs are computed for each service or class of services by applying average malpractice insurance historical practice cost percentages to the estimated average allowed charge during the 1991 base period.

(2) The average historical malpractice insurance percentage for a service or class of services is computed as follows:

(i) Multiply the average malpractice insurance percentage for each specialty by the proportion of a particular service or class of services performed by that specialty.

(ii) Add all the products for all the specialties.

(3) For services furnished in the year 2000 and subsequent years, the malpractice RVUs are based on the relative malpractice insurance resources.

[56 FR 59624, Nov. 25, 1991, as amended at 57 FR 42493, Sept. 15, 1992; 58 FR 63687, Dec. 2, 1993; 62 FR 59102, Oct. 31, 1997; 63 FR 58910, Nov. 2, 1998; 64 FR 59441, Nov. 2, 1999; 65 FR 25668, May 3, 2000; 65 FR 65440, Nov. 1, 2000; 67 FR 43558, June 28, 2002; 68 FR 63261, Nov. 7, 2003; 72 FR 66932, Nov. 27, 2007; 73 FR 69935, Nov. 19, 2008; 76 FR 73471, Nov. 28, 2011; 81 FR 79879, Nov. 14, 2016; 81 FR 80553, Nov. 15, 2016]

§ 414.24 Publication of RVUs and direct PE inputs.

(a) *Definitions.* For purposes of this section, the following definitions apply:

Existing code means a code that is not a new code under paragraph (c)(2) of this section, and includes codes for which the descriptor is revised and codes that are combinations or subdivisions of previously existing codes.

New code means a code that describes a service that was not previously described or valued under the PFS using any other code or combination of codes.

(b) *Revisions of RVUs and Direct PE Inputs.* For valuations for calendar year 2017 and beyond, CMS publishes, through notice and comment rulemaking in the FEDERAL REGISTER (including proposals in a proposed rule), changes in RVUs or direct PE inputs for existing codes.

(c) *Establishing RVUs and Direct PE inputs for new codes*—(1) *General rule.* CMS establishes RVUs and direct PE inputs for new codes in the manner described in paragraph (b) of this section.

(2) *Exception for new codes for which CMS does not have sufficient information.* When CMS determines for a new code that it does not have sufficient information to include proposed RVUs or direct PE inputs in the proposed rule, but that it is in the public interest for Medicare to use a new code during a payment year, CMS will publish in the FEDERAL REGISTER RVUs and direct PE inputs that are applicable on an interim basis subject to public comment. After considering public comments and other information on interim RVUs and PE inputs for the new code, CMS publishes in the FEDERAL REGISTER the final RVUs and PE inputs for the code.

(d) *Values for local codes (HCPCS Level 3).* (1) Carriers establish relative values for local codes for services not included in HCPCS levels 1 or 2.

(2) Carriers must obtain prior approval from CMS to establish local codes for services that meet the definition of ''physician services'' in § 414.2.

[56 FR 59624, Nov. 25, 1991, as amended at 57 FR 42492, Sept. 15, 1992; 79 FR 68003, Nov. 13, 2014]

§ 414.26 Determining the GAF.

CMS establishes a GAF for each service in each fee schedule area.

(a) *Geographic indices.* CMS uses the following indices to establish the GAF:

(1) An index that reflects one-fourth of the difference between the relative value of physicians' work effort in each of the different fee schedule areas as